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AUTHOR Antonelli, Charles J.
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ABSTRACT

The concept of treatment/therapy with children exhibiting antisocial maladaptive behavior is analyzed. The process of assessing the individual and planning treatment in a multidisciplinary team setting is discussed. Suggestions are made for treating maladaptive behaviors or teaching adaptive behaviors, and guidelines (such as defining targeted behaviors, reviewing possible side effects of medication, implementing medical and/or program changes in a systematic manner to allow for analysis, and evaluating environmental conditions) are listed. Research is cited on teaching adaptive skills to severely and profoundly retarded persons, and a staff assistance scale (in which gradually increased levels of staff help are provided on a task) is presented for evaluating the individual's skills. The staff assistance scale may be combined with task analysis to begin to measure learning rates and progress to independence. (CL)

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Guidelines for Working with Clients/Students Who Engage in Disruptive-Aggressive Behavior and/or Have Adaptive Behavior Deficits

Charles J. Antonelli
Psychologist
Macomb-Oakland Regional Center

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Prepared for the Michigan Council of Exceptional Children Conference
Grand Rapids, Michigan

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Introduction:

The intent of this paper is to elaborate on the methodology utilized in treating persons who engage in antisocial maladaptive behavior and those who demonstrate a need to learn adaptive behavior skills. Recent trends in the field of psychology indicate that therapists and clinicians can provide more effective treatment to clients when the interdisciplinary method is applied. The present study will outline a series of methods which may provide the clinical team with guidelines for evaluating and treating clients. The unpredictable nature of human behaviors have presented the clinical team and society with a variety of concerns regarding the "need for treatment" as well as the "right to treatment" of persons who are antisocial or have maladaptive characteristics. The unpredictable nature of human behavior is made more complex when unsound behavior analysis or clinical evaluations are utilized as a basis for client treatment. In essence, the degree to which human behavior is unpredictable remains unknown and can only become more unknown when clinical teams are not effective in the evaluation and analysis of behavior. In the past, the fields of medicine and behavior analysis appeared incompatible when trends commonly labeled "Medical Model" and "Behavioral Model" were stylish euphamisms. It is refreshing to see the fields of medicine and psychology converge to form a coordinated and more scientific approach to client treatment. (Miniszek, 1983; Antonelli, 1982)

Method:

Idealistically, a clinical team would prefer the opportunity to obtain a current set of observational data when maladaptive behaviors emerge. Occasionally, the teams may not obtain such observations due to (1) the brief occurrence of the behavior, or (2) staff who are so surprised by the emergence and disappearance of the maladaptive behavior that they are not aware of

stimuli which provoked the response. Behaviors which are episodic in that their occurrence is observed once every two years, once a year or very sparsely during a year often frustrate clinical teams. Typically, the team is left with a memory of the client's potential or ability and no sound method of analysis or program preparedness.

In these cases, the author suggests an on-going monitoring of medical and environmental conditions and training to increase staff awareness so that they are prepared to make more reliable observations of intermittent/unexpected behaviors. Even though this paper appears to stress the emergence of maladaptive behavior, this same effect is observed with respect to skill acquisition and adaptive behavior. A client who typically requires staff assistance to complete a skill may perform independently for a short period of time prior to regressing to previous levels of dependence.

Some questions the clinical team must consider when treating maladaptive behaviors or teaching adaptive behaviors include:

1. Was or is there time to do something about the behavior besides observe it; and utilize emergency methods to protect life?
2. What are the risks and advantages of treating the behavior? e.g., will a treatment procedure increase a maladaptive behavior which would "naturally" decrease or, as some would say, "run its course?"
3. If alleged treatment is being provided, is it based on a sound analysis, legally justified, or applied due to partisan pressure? Can the methods used be verified scientifically and/or clinically? In essence, if we choose to do something about the behavior, "do we know what we are doing, as well as why we are doing it?"

Essentially, prior to considering treatment, the following considerations are suggested:

1. Protect the client from himself and protect other persons.

2. Determine if the maladaptive should be treated and identify a sound course of treatment.

The clinical team should avoid the following assumptions and situations:

1. That the client is in good health based on outdated medical information.
2. That behavioral and/or medical treatment programs will not be effective based on undocumented past attempts.
3. Treating the client based on professional opinions which are not based on a sound analysis.
4. That they should "do something" to satisfy a special interest group or persons who pressure or influence treatment which is not based on a sound analysis.
5. Cookbook behavior modification methodology.

Typically, when the clinical team treats a client based on assumptions and unsound analysis, the behavior may increase, escalate in intensity, and/or the client may learn various escape and avoidance behaviors which are undesirable. Another issue which occurs is the client's behavior may decrease in spite of the "treatment" or "help" provided. In essence, the clinical team will "not know" what changed the client's behavior and will be more frustrated when the same "treatment" fails during future episodes. Antonelli and Others, in press, a and b, suggested the following guidelines which the clinical team might consider when formulating client treatment programs:

"1. Define what behaviors must be increased, decreased, taught or regulated to increase normative social behavior and acceptance.
2. Obtain a current medical review or physical examination, e.g., allergies, illness, seizure activity, infections, constipation.
3. If the client is taking medications, review possible side effects and rule out toxicity.
4. Does the behavior occur with respect to a (1) cycle (occurring,

stopping and reoccurring), or (2) season or month of the year? Collect A.B.C. Data, noting the behavior, antecedents, consequence, time of day, staff present, and location.

5. Review past records with respect to long term and recurrent medical conditions.
6. Does historical data exist of the client's behavior during medical condition episodes, as well as under "normal" conditions?
7. Implement medical and/or program changes in an individualized, systematic manner so that an analysis is possible.
8. The maladaptive behavior may appear motivated by a need for attention. The attention factor may require direct manipulation to determine if the client in fact engages in the behavior to receive attention.
9. Environmental conditions must be evaluated and factors such as the risks of providing treatments to the client in his current placement should be considered.
10. Is the client experiencing any apparent biological developmental change, e.g., teething, menstruation, cataracts?
11. Recent dietary changes, increase or decrease, liquid food intake, food refusal. Do any hypoglycemic or diabetic conditions exist?
12. Any change in sleeping pattern and toileting elimination pattern?

The guidelines may provide a framework for obtaining the information for understanding an individual's motivation and learning, as well as the medical-behavioral interface. (Brena, 1982)"

Some additional considerations might be reviewed when teaching adaptive behavior skills:

Antonelli and Olson, 1981, and Antonelli and Crowley, 1982, demonstrated that clients with limited self care skills, social interaction skills,

and verbal skills could benefit from small group therapy. The study demonstrated that the subjects learned to respond to abbreviated and multi-word instructions at increased levels of independence. The data in this report did not completely isolate the instruction characteristics to which the client was responding. For example, when the instruction "stand" was presented, some clients would attempt to sand when sanding materials were present. The same clients would respond to the instruction "stand up" by standing.

Berman (1973), Diebert and Harmon (1973), Cronin (1977), and Michaelis (1978), indicate that the following considerations must be observed when working with severely and profoundly retarded persons:

1. Does the person understand the language?
2. Has the person had the opportunity to learn what specific instructions mean?
3. With tasks involving the hands, are we utilizing the client's dominant hand?

The study attempted to evaluate what characteristics of specific instructions or instructors individual clients responded to by utilizing task analyzed procedures and the following staff assistance scale (Antonelli and Others, 1980, and Jackson and Antonelli, 1978):

Always provide the subject with the opportunity to perform at his/her most independent level. Begin at level 9; if the subject does not perform, go to level 8; if the subject does not perform, go to level 7; etc., until the subject performs the task.

9. <u>Self-initiates task (completes task)</u>:

   The subject will obtain task materials and initiate task, complete task, and put materials away without any assistance speci-

fied in 2 through 8.

8. Completes task with experimenter proximity:

The subject will be rated 8 under the following condition:

a. The subject will perform the task completely after task materials are presented. The experimenter is present in the training area but does not interact with assistance levels 2 through 7. The subject will not respond to assistance level 9.

7. Completes task when verbal or signed instructions are given prior to task:

The subject will be rated 7 under the following condition:

a. The subject will perform the task completely after being instructed to perform the task. The subject will not require physical prompts, demonstrations or models, gestures or any additional verbal prompts after the initial verbal instruction. The subject will not respond to assistance levels 8 through 9.

6. Completes task with verbal or signed instructions and experimenter proximity:

The subject will be rated 6 under the following conditions:

a. The subject will perform the task while receiving verbal prompts on the complete task or on specific components of the task. No physical contacts or prompts are required. No models or demonstrations are required. No gestures--pointing, eye shifting, arm gestures or head nodding. The subject has not responded to assistance levels 7 through 9.

5. Completes task with verbal or signed instruction and gestural prompt:

The subject will be rated 5 under the following conditions:

a. The subject will perform the task requiring verbal prompts and gestures on the complete task or on specific components

of the task.

b. Gestures are defined as pointing, arm gestures, head nodding, eye shifting. No physical contacts or prompts are required. No models or demonstrations are required. The subject has not responded to assistance levels 6 through 9.

4. Completes task with modeling demonstration and verbal or signed instructions:

The subject will be rated 4 under the following conditions:

a. The subject will perform the task after a modeling demonstration and verbal instructions are given and may require further demonstration on any part of the task. No physical assistance is required. The subject has not responded to assistance levels 5 through 9.

3. Completes task with intermittent physical assistance:

The subject will be rated 3 under the following conditions:

a. The subject will perform at least one component of the task not requiring complete manual guidance.

b. The subject will perform at least one component of the task not requiring continual physical contact. The subject has not responded to assistance levels 4 through 9.

2. Completes task with continuous physical assistance:

The subject will be rated 2 under the following conditions:

a. The subject will perform the task from initiation to completion only if he is manually guided to perform all components of the task.

b. The subject will perform the task from initiation to completion only if physical contact is made continually from beginning of task to completion. This physical contact may

not be related to performance on components but may be resting a hand on the subject's shoulder. The subject has not responded to assistance levels 3 through 9.

1. Fails to complete task:

The subject will be rated 1 under the following condition:

a. The subject does not perform any components of the task. Does not perform task even when complete manual guidance is provided. The subject has not responded to assistance levels 2 through 9.

In addition to monitoring daily progress of clients, this same rating scale was utilized successfully to facilitate self management in teaching clients to relax as an alternative to aggressive, disruptive behavior. One client was reinforced for relaxing independent of staff assistance in an unpublished case study conducted by Killebrew, 1979. Essentially, if the client was upset and calmed herself down or remained calm for specified periods of time, she would receive an 8 or 9 on her card. The degree of staff assistance to calm was rated depending on the staff involvement needed. If the client received 8 and 9 ratings for a specified number of days, bonus reinforcers were delivered.

Utilizing Task Analysis:

When baselining a behavior, such as handwashing, bed making, etc., it is suggested that at least 10 days of observation be made so that the client's response to a variety of staff is observed. Typically, one finds that a client's level of independence will vary in that some staff will motivate more independent functioning. When this trend is observed, those staff can serve as trainers and/or models so that independent functioning can be generalized across staff.

At times, a client may be expected to complete a skill following each step of the task analysis. The baseline should attempt to identify if the client can complete the skill or any component of the skill. The task analysis should only teach the client those components of the skill that are not performed adequately or not performed. Some clients can become frustrated when we attempt to teach them something which they already know. In essence, the task analysis should allow for a degree of individual style or variance as long as the outcome is within socially acceptable limits.

By combining the staff assistance rating scale with task analyzed procedures, we can develop an emperical basis for monitoring client learning rates and progress toward independence. (Antonelli and Others, 1980; Jackson and Antonelli, 1978; Antonelli, 1974)

Where to Begin?

Assume that we don't know anything and only after viewing the client as an individual might we begin to learn.

The general rules to be followed prior to instituting an adaptive behavior program, as well as maladaptive reduction programs, begin with data collection and ruling out medical factors and probable risk or injury which may result from treatment procedures. Medical factors may include physical condition, range of motion, need for special equipment, current medications, sensory evaluation with respect to the method utilized in training, e.g., the client should be able to "see" a visual model and "hear" verbal models.

The treatment of regression or loss of independent functioning, as well as the emergence and maintenance of maladaptive behavior, remains an ongoing objective of study for clinical teams. Even with today's vast knowledge of motivation and medicine, we have only learned to prolong life and maintain the life of organs and the body, yet the complexity of the

brain and emission of behavior remains mysterious and unknown. This complexity of individual beings should be the focus of clinical treatment teams. The relationship of physical conditions and behaviors can be demonstrated with individual case studies as well as in the research literature. (Azria, Holtz, 1966; Miniszek, 1983) This clinical approach is much more involved than mere behavior analysis and must coordinate a total approach involving the physiological sciences so that the welfare of the client is not compromised.

In Conclusion:

The concept of treatment/therapy can only be realized on a case by case, individual basis. The concept is grounded in the clinical team's ability to complete a thorough analysis of the situations and factors which relate to the individual case. Active analysis can generate procedures which relate to specific persons. The procedures may include:

1. Improving staff awareness with respect to those medical and environmental conditions which tend to preceed the emergence of maladaptive behavior and maintain maladaptive behavior.
2. Emphasis on observing clients and studying them during those periods of (1) decreased or absence of maladaptive behavior, and (2) acquisition of adaptive skills. Essentially, study why the client is doing well in terms of his medical and environmental state.
3. Informing staff of what medical or environmental conditions should be initially evaluated when clients demonstrate (1) regression or non-compliance in adaptive skills, or (2) escalations or emergence of maladaptive behavior.
4. Systematically applying procedural changes. If a medical factor is being evaluated, hold programmatic variables constant. The

process of systematic application will provide the basis for medical or programmatic interventions which may constitute components of "preparedness and prevention approaches".

5. Global Behavioral Assessments which monitor (1) overall trends and variance in acquisition and performance of adaptive behavior, and (2) correlations with maladaptive behavior and environmental and/or medical factors.
6. The behavior analysis component must be on-going so that medical and programmatic interventions are validated as well as updated with current information.

One factor which increases the complexity of the treatment program is prediction. A recent National Institute of Mental Health Report found that predictions of aggression were wrong 95% of the time, as contrasted with clinicians who held that their ability to predict aggression was correct an average of 40 to 46% of the time.

The clinical team must understand that human behavior will continue and what is initially required is a current and on-going analysis to determine the best course of treatment with respect to environmental/medical conditions. (Antonelli and Others in press) Finally, we can be as precise as the current state of technology allows yet, in the course of individual treatment, we may happen on a valuable program which works reliably but remains a mystery as to why.

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